DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

MAR 31 2006

SMDL #06-008

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005, Public Law Number 109-171. Section 6044, State Flexibility in Benefit Packages, adds a new section 1937 to the Social Security Act (the Act). Under section 1937, States have the option to amend their State plan to provide alternative benefit packages to beneficiaries, without regard to comparability, statewideness, freedom of choice, or certain other traditional Medicaid requirements. These benchmark plans may be familiar to you because they are the same benchmark plans that are currently in place in the State Children's Health Insurance Program. This provision is effective March 31, 2006. A State plan amendment (SPA) preprint is enclosed with this letter to assist you in submitting an amendment.

Beneficiaries Subject to the Provision

Under section 1937 of the Act, the State may require that medical assistance to individuals, within one or more groups of individuals specified by the State, be provided through enrollment in benchmark coverage or benchmark-equivalent coverage. A State may only require that individuals obtain benefits by enrolling in such coverage if they are a "full benefit eligible" in an eligibility category established under the State plan on or before February 8, 2006, and are not within exempted categories under the statute. Full benefit eligible individuals are individuals who would otherwise be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan, but do not include individuals determined eligible by the State for medical assistance under section 1902(a)(10)(C) of the Act, or by reason of section 1902(f), or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care (medically needy and spend-down populations). Generally, these individuals are healthy adults and healthy children on Medicaid.

Individuals under age 19 who are covered under the State plan under section 1902(a)(10)(A) of the Act must receive wrap-around benefits to the benchmark, or benchmark-equivalent plan, consisting of early and periodic screening, diagnostic, and treatment (EPSDT) services defined in section 1905(r). Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit. The State plan must include a description of how wrap-around benefits or additional services will be provided to ensure that these beneficiaries receive full EPSDT services. In accordance with section 1905(r), EPSDT services must be medically necessary services.

The following are categories of individuals who may not be required to enroll in an alternate benefit plan:

1. The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

2. The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

3. The individual is entitled to benefits under any part of title XVIII.

4. The individual is terminally ill and is receiving benefits for hospice care under title XIX.

5. The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

6. The individual is medically frail or otherwise an individual with special medical needs (as designated by the Secretary). For purposes of this section, the Secretary designated individuals with special needs to include those groups defined by Federal regulations at 42 CFR 438.50(d)(1) and (3) of the managed care regulations (i.e., dual eligibles and certain children under 19 who are eligible for SSI; eligible under section 1902(e)(3) (TEFRA children); in foster care or other out of home placement; receiving foster care or adoption assistance; or, receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as defined by the State in terms of either program participation or special health care needs).

7. The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

8. The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

9. The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after welfare reform effective date defined in section 1931(i)). This provision relates to those individuals who qualify for Medicaid solely on the basis of qualification under the State's TANF rules (i.e., the State links Medicaid eligibility to TANF eligibility).

10. The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa). This provision relates to those individuals who are eligible for Medicaid based on the breast or cervical cancer eligibility provisions.

11. The individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII).

12. The individual is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

There may be instances in which an exempted individual may benefit from enrolling in an alternative benefit package. States are permitted to offer them such a package but may not require them to enroll in one. For example, in some States the State employee benchmark coverage may be more generous than the State Medicaid plan. Secretary-approved coverage may offer the opportunity for disabled individuals to obtain integrated coverage for acute care and community-based long-term care. (See discussion of alternative benefit options below.)

In any case in which a State offers an individual the option to enroll in an alternative benefit package, the State must inform the individuals that such enrollment is voluntary and that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan. The State must inform the individual of the benefits available under the alternative benefit package and provide a comparison of how they differ from the benefits available under the regular Medicaid program. The State must document in the individual's eligibility file that the individual was informed in accordance with this paragraph and voluntarily chose to enroll in the alternative benefit package.

Benchmark Benefit Coverage
Benchmark coverage is described as any one of the following:

Federal Employees Health Benefit Plan (FEHBP – Equivalent Health Insurance Coverage). The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in and offered to Federal employees under 5 U.S.C. 8903(1).

State Employee Coverage. A health benefits plan that is offered and generally available to State employees in the State involved.

Health Maintenance Organization (HMO) plan. A health insurance plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

Secretary Approved Coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage. States wishing to opt for Secretarial approved coverage should submit a full description of the proposed coverage and include a benefit by benefit comparison of the proposed plan to one or more of the three Benchmark plans specified above as well as a full description of the population that would be receiving the coverage.

A State may select one or more benchmark coverage plan options. The State may also specify the benchmark plan for any specific beneficiary. For example, one beneficiary may be enrolled in the FEHBP and another may be enrolled into State Employee Coverage at the option of the State.

Benchmark-Equivalent Benefit Coverage
If a State designs or selects a benchmark plan other than those specified above the State must comply with the following conditions:

1. The benchmark-equivalent benefit package has an aggregate actuarial value, as determined in an actuarial report discussed below, that is at least equivalent to the actuarial value of one of the Benchmark Benefit Packages described above.

2. Benchmark-equivalent coverage must include coverage for the following categories of services: 1) Inpatient and outpatient hospital services; 2) Physicians' surgical and medical services; 3) Laboratory and x-ray services; 4) Well-baby and well-child care, including age-appropriate immunizations; and 5) Other appropriate preventive services, as designated by the Secretary. At this time, the Secretary has not designated any other preventive services.

3. If the benchmark coverage package used by the State as a basis for comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes the following four categories of services: prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for such category of service in the benchmark plan used for comparison by the State. If the benchmark coverage package does not cover one of the four categories of services mentioned above, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

4. If the State chooses to provide benchmark-equivalent coverage, the State must submit, as part of its SPA, an actuarial report. The actuarial report must contain an actuarial opinion that the health benefits coverage meets the actuarial requirements described in paragraphs 1-3 above. The actuarial report must be prepared by an individual who is a member of

the American Academy of Actuaries: a) using generally accepted actuarial principles and methodologies; b) using a standardized set of utilization and price factors; c) using a standardized population that is representative of the population involved; and d) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. The actuary preparing the opinion must select and specify the standardized set of factors and population to be used in (b) and (c) above. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

Employer Sponsored Insurance Health Plans

Use of benchmark or benchmark-equivalent benefit coverage is at the discretion of the State and may be used in conjunction with employer sponsored health plans as a coverage option for individuals with access to private health insurance. For example, if an individual has access to employer sponsored coverage and that coverage is determined by the State to be benchmark equivalent, a State may, at its option, provide premium payments on behalf of the beneficiary to purchase the employer coverage. The premium payments would be considered medical assistance and the State could require the beneficiary to enroll in the group health plan.

Payment of Premiums

Payments of premiums for benchmark or benchmark-equivalent coverage shall be treated as payments for medical assistance.

Option to Provide Additional Wrap-Around Services

If the State opts to provide additional wrap around services to the benchmark or benchmark-equivalent plans, the State plan must describe the populations covered and the procedures for assuring those services.

Coverage of Rural Health Clinic and FQHC Services

If a State provides benchmark or benchmark-equivalent coverage to individuals, it must assure that the individual has access, through such coverage or otherwise, to rural health clinic services and FQHC services as defined in subparagraphs (B) and (C) of section 1905(a)(2). Payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act.

Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

Compliance with the Law
States will be required to continue to comply with all other provisions of the Act in the administration of the State plan under this title.

Submission Procedures
As previously mentioned, this provision is effective March 31, 2006. State plans submitted by June 30, 2006, may be approved retroactively to the first day of the quarter (i.e., April 1, 2006) and would be subject to the traditional State plan review process. Please submit your SPA electronically in a "pdf" file format to your regional office in order to implement these provisions.

The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children's Health Program Group, who may be reached at (410) 786-5647. If you have any additional questions, please let us know.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Senior Director, Access Policy
Association of State and Territorial Health Officials

Christie Raniszweski Herrera
Director, Health and Human Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments